

ASB License Application (status Processed)

Please answer all questions completely and accurately to avoid unnecessary delays in processing. Return the completed application, with the required fee to the address below 30 days prior to the opening of the program or the expiration of your current certificate. Note: This application is an open record and available to the public.

Type of Application

☐ Amendment* ☐ Change of Ownership ☐ Initial ☒ Recertification

* Please specify the reason for the amendment (i.e., Program name change, % ownership change of an interested party):

GENERAL INFORMATION
Facility Name (Doing Business As) * River Bend Retirement Community
Previous Name (if applicable)
Street Address (physical location) * 813 Tyler Street NE
City * Cascade
County Dubuque
State * Iowa
Zip * 52033-____
Mailing Address (if different from physical location)
City
County
State
Zip
CERTIFICATE TYPE (CHOOSE ONE) AND FEE STRUCTURE
☒ Assisted Living Programs ☐ Assisted Living Programs for People with Dementia ☐ Elder Group Homes ☐ Adult Day Services
Intermediate, Residential, and Nursing Facilities: Initial Certificate - \$750 Recertification - \$1000 Accreditation via a national body of accreditation (ALP and ADS only) - \$125
Total Number of Dwelling Units: 44 If an Assisted Living Program, Number of Dwelling Units: General Population Dementia Specific Maximum Occupancy: 83
Fee Submitted:
Certificate Holder is the ☒ owner(s)/lessor(s), ☐ lessee, or ☐ management company. The Certificate Holder is the person(s) or business entity ultimately responsible for the operation of the program and with the authority to direct the management and policies of the program.

ADMINISTRATION
A. Program Manager
Last Name * Koopmann
First Name * Jill
Email rbmanager@riverbendal.com
* Indicate whether the Program Manager is also the designee (person authorized to accept personal service and receive registered and certified mail). If "No," complete the Designee section. ☒ Yes ☐ No
Note: Any changes to the Program Manager should be reported to the Department in writing within ten (10) business days of the change.
B. Designee
Name - Designee
Title
Email

OWNERSHIP INFORMATION

A. Owner(s)/Lessor(s)

Name - Owner(s)/Lessor(s)

Callahan Construction, Inc

Street Address (physical location)

7629 Commerce Park

City

Dubuque

County

Dubuque

State

Iowa

Zip

52002-____

Mailing Address (if different from physical location)

813 Tyler St NE

City

Cascade

County

Dubuque

State

Iowa

Zip

52033-____

Telephone Number

(563) 852-5001

FAX Number

(563) 852-5154

E-Mail Address

rbmanager@riverbendal.com

Contact Person

Jill Koopman

Telephone Number

(563) 852-5001

B. Type of Organization (check type of Organization) *

Governmental

- ☐ City
☐ County
☐ State
☐ Federal
☐ City/County
☐ Tribal

Proprietary

- ☐ Sole Proprietary
☐ Partnership
☐ Corporation
☒ Limited Liability Company
☐ Limited Liability Partnership
☐ Trust

Voluntary Non-Profit

- ☐ Corporation
☐ Church
☐ Association
☐ Church/Corporation
☐ Private Non-Profit
☐ Limited Liability Company
☐ Limited Liability Partnership
☐ Trust

C. Interested Parties
List all the names, addresses, and percentages of stock, shares, and partnerships or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners, or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list no later than 10 working days after the effective date of the changes.
Is the facility leased? * ☐ Yes ☒ No If "Yes", add lessee information here. If "No", skip to Section E.
D. Lessee information (if the lease includes sub-leases, complete for all parties)
F. Subsidiary/Parent Information
Is the applicant a subsidiary company, either wholly or partially owned by another organization or business? * ☐ Yes ☒ No If "Yes," please provide the following information:
Legal Business Name - Parent Corporation
DBA (Doing Business As)
Type of Ownership
Address
City
State
Zip
Contact Person
Telephone Number
G. Chain Organization
Is the applicant under the control of a chain organization? * ☐ Yes ☒ No Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other device, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each program for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, providers/suppliers cost reports, etc. In addition, a chain program would not necessarily be a subsidiary of the parent corporation but the chain program or programs could be owned by different subsidiaries of the same corporation parent.
Name - Chain Organization
If the applicant/licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP): 1. Provide the names and addresses of all LLCs, LLPs or any other type of entity that any of the member(s) of the applicant are also members, officers, directors and/or board members. 2. Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLCs, LLPs involved with the applicant and its members.

MANAGEMENT COMPANY
Is the operation of the program under a management contract? * ☐ Yes ☒ No If "Yes," provide the following information regarding any management company retained to operate this program.
Type of Management Company:
If "Other," please specify:
Name - Management Company
Name - Contact Person
Telephone Number
Address
City
State
Zip
Please identify officers, directors, trustees or supervisors of the management company.

FUNDING - FOR ASSISTED LIVING PROGRAMS ONLY
Is the Program considered an Affordable Assisted Living Program, which is built with low-income housing tax credits? * ☐ Yes ☒ No
Will the Program participate in the Medicaid Home and Community-Based Services (HCBS) Waiver program? * ☒ Yes ☐ No
Will the Program participate in the HCBS Rent Subsidy Waiver or HUD Section 8 Rental Vouchers program? * ☒ Yes ☐ No

STRUCTURE (FILL IN STRUCTUAL INFORMATION SHEET REGARDING DWELLING UNITS)
A. Is the program attached to one of the following: ☐ RCF ☐ NF ☐ Hospital ☐ Freestanding
B. Is the Program part of a licensed Continuing Care Retirement Community (CCRC)? * ☐ Yes ☒ No
C. What is the targeted opening date of the new program?
D. For Recertification only: Have there been any structural modifications to the building since the most recent state certification? * ☐ Yes ☒ No If you answered "Yes", please provide the month and year of the completion of the modification(s): Month/Year

OTHER BUSINESS/ACTIVITY
Please list all other business(es) or activity(ies) located in the program, such as respite care, physical therapy, occupational therapy, etc.:

TARGET CLIENTELE
Please describe the clientele to be served (i.e. Intellectually Disabled, Brain Injury, Dementia, Elderly, etc.): Elderly, Dementia

EMERGENCY RESPONSE SYSTEM
Will the program have staff on-site on a 24-hour/day basis to respond to emergency situations? * ☒ Yes ☐ No If you checked "No", please annotate the staff's emergency response time in minutes:

FOOD SERVICE
The program will serve 3 meals each day in a common dining room. Meals will be prepared: ☒ On-site, a copy of the food service establishment or nursing facility license is attached ☐ Off-site, a copy of the provider's food service establishment or nursing facility license is attached

ADVERSE ACTION - TO BE COMPLETED BY NEW APPLICANTS ONLY
Within the last 10 years, has any adverse action(s) initiated by another state license agency (other than Iowa) resulted in the denial (D), suspension (S), or revocation (R) of a license or certificate held by the owner/lessor, lessee, interested parties, parent corporation, "home office" of a chain organization and/or any of the members of a LLC/LLP? ☐ Yes ☒ No If "Yes," please add below:
Adverse Actions

OTHER PROVIDERS
Identify the other types of providers owned by the applicant/licensee.

APPLICANT/LICENSEE - TO BE COMPLETED BY NEW APPLICANTS ONLY
If the applicant/licensee has never been licensed to operate a program in the State of Iowa, we request that you provide resumes for each officer (if the applicant is a corporation) or each partner (if partnership) or member (if limited liability company), etc. to assist the Department in determining the applicant's ability to operate a program.

CONTACT PERSON
Identify the person responsible for completing this application and who can be contacted if we have questions.
Name * Jill Koopmann Title Manager Telephone Number * (563) 852-5001 FAX Number (563) 852-5154 E-Mail Address rbmanager@riverbendal.com

DISCLOSURES
1. In accordance with 481 IAC 69.4(3), 68.4(3) or 70.4(3), do any of the individuals referred to in the "Interested Parties" sections of this application have, or have they had, any ownership interest in an adult day service program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code chapter 135C, or a licensed hospital as defined in Iowa Code chapter 135B, which has been closed in any state due to removal of program, agency, or facility licensure or certification, due to involuntary termination from participation in either the Medicare or Medicaid Program, or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants, or participants. 2. In accordance with 481 IAC rules 68.4(2), 69.4(2), or 70.4(2), have any of the individuals referred to in the "Interested Parties" section of this application been convicted of a felony, aggravated or serious misdemeanor or found in violation of the child abuse or dependent adult abuse laws of any state. ☐ Yes ☒ No If "Yes," please provide an explanation in an attached file.

AFFIRMATION STATEMENT
I hereby affirm to the best of my knowledge that the information in this application is complete and accurate. I assure the owner(s) of the program named herein will work with the Department of Inspections and Appeals, Department of Public Safety, and others as deemed necessary, to bring the program into full compliance with the requirements of Iowa Code chapters 231B, 231C, or 231D; 481 Iowa Administrative code chapters 67, 68, 69 or 70; and other applicable local, state, and federal regulations. Please print Affirmation Print, sign, date and attach the Affirmation Statement.

Included Files					
File Name	File Type	File Date	File Description	Action	
Affirmation .pdf	Attestation/Affirmation	04/09/2026			
Food License.pdf	General	04/09/2026			

Facilities Contact
Phone: 515.381.7272
Email: healthfacilities@dia.iowa.gov

Direct Care Worker/CNA and Health Care Employment Agency Contact
Phone: 515.381.7835
Email: DCW@dia.iowa.gov

Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321-1270



KIM REYNOLDS, GOVERNOR
CHRIS COURNOYER, LT. GOVERNOR

AARON BAACK, INTERIM DIRECTOR

July 22, 2026

rbmanager@riverbendal.com

Jill Koopmann, Administrator
River Bend Retirement Community
813 Tyler Street NE
Cascade, IA 52033

RE: S0237

Dear Ms. Koopmann:

Enclosed please find the new certificate to reflect your current status. Display it in a conspicuous place in the program, which is viewed by the public. Please destroy the previously posted certificate.

Sincerely,

A handwritten signature in cursive script that reads "Catie Campbell".

Catie Campbell | Unit Manager
Iowa Department of Inspections, Appeals & Licensing
Health & Safety Division, Acute & Continuing Care
6200 Park Avenue, Suite 100, Des Moines, IA 50321-1270
515-669-3089 mobile
catie.campbell@dia.iowa.gov | dial.iowa.gov

Enclosure: program certificate

Post in conspicuous place

Nontransferable

State of Iowa

Department of Inspections, Appeals, and Licensing

This certifies that

River Bend Retirement Community

has been granted a certificate for an

Assisted Living Programs

for the address:

813 Tyler Street NE

Cascade, Iowa 52033

authorizing operation as specified by Iowa law.

License #: S0237
Units: 44
Max. Capacity: 83
Issued: July 25, 2026
Expires: July 24, 2028



Aaron Baack, Interim Director

A certificate is hereby granted to the above-named facility to operate in accordance with Iowa Code chapter 231C and the rules and regulations promulgated thereunder. This certificate shall not be transferable or assignable, except with the written approval of the Health & Safety Division of the Iowa Department of Inspections, Appeals, and Licensing and shall be subject to suspension or revocation for failure to comply with Iowa Code chapter 231C or the rules or minimum standards adopted pursuant to chapter 231C.